



**Brooks County Schools**  
1081 Barwick Road, Quitman, Georgia 31643  
Dr. Vickie Reed, Superintendent

**Records Release**

The following student has requested enrollment in the Brooks County School System:

Student's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

School Last Attended \_\_\_\_\_

School Address \_\_\_\_\_

School Phone Number \_\_\_\_\_ School Fax Number \_\_\_\_\_

Please release the following portion of the records regarding this student, which includes:

_____ Transcript of Student Grades	_____ Attendance (including days on roll and absences)
_____ Withdrawal Grades	_____ Birth Certificate and Social Security Card
_____ Test Scores	_____ Immunization Records (GA3231)
_____ BLT (Basic Literacy Test) Results	_____ Ear/Eye/Dental Record (GA3300)
_____ SST Documentation	_____ Special Education Folder (including
_____ Disciplinary Record	_____ Psychological, Eligibility Report, IEP, etc.)
_____ Gifted / EL / Migrant / RTI / etc.	_____ 9 <sup>th</sup> Grade Entry Date (mm/dd/yy) if applicable
Other _____	

Please send records to: \_\_\_\_\_ Phone \_\_\_\_\_  
\_\_\_\_\_ Fax \_\_\_\_\_  
\_\_\_\_\_

House Bill 180 requires that the parent indicate whether the student is currently serving a suspension or expulsion from another school, the reason for that action, and the term of the action.

Suspension [ ☐ ] Yes [ ☐ ] No

If you answered yes, please state the reason for that action on the lines provided: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Term of Action: \_\_\_\_\_

House Bill 180 specifically provides that if a student who has been conditionally admitted if "found to be ineligible" under the provisions of the new School Safety Act then the student "shall be dismissed from enrollment until such time as he or she becomes so eligible."

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

160-5-1-.12 STUDENT FEES AND CHARGES/REQUIRED STUDENT EQUIPMENT AND MATERIALS.  
(h) Local units of administration shall not withhold any student record because of nonpayment of fees. However, schools may withhold grad cards, diplomas, or certificates of progress until fees are paid. Authority O.C.G.A. §20-2-133; 20-2-1013. Op. Atty. Gen. 85-35.

FERPA allows schools to disclose those records, with consent, to the following parties or under the following conditions (34 CFR § 99.31): School officials with legitimate educational interest; Other schools to which a student is transferring.

# Brooks County School System Student Registration

OFFICE USE ONLY: Student #: \_\_\_\_\_ School Assigned: \_\_\_\_\_ Grade: \_\_\_\_\_ Entered by/Date: \_\_\_\_\_  
Residency \_\_\_\_\_ Birth Certificate \_\_\_\_\_ Social Security Card \_\_\_\_\_ GA Immunization \_\_\_\_\_ Ear/Eye/Dental Form \_\_\_\_\_ Out of Attendance Zone \_\_\_\_\_ Sealed Transcript \_\_\_\_\_  
Copy to: Spec Ed \_\_\_\_\_ 504 \_\_\_\_\_ Gifted \_\_\_\_\_ ESOL \_\_\_\_\_ Migrant \_\_\_\_\_ EIP \_\_\_\_\_ REP \_\_\_\_\_ ALT\* \_\_\_\_\_ Social Services \_\_\_\_\_ Other \_\_\_\_\_ (Rev. 3-18)

**STUDENT'S FULL LEGAL NAME:**

Last	First	Middle	Jr., II, III, etc.
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GRADE: \_\_\_\_\_ GENDER: M / F DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ STUDENT SS#: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Circle One) MM/DD/YY (Waiver available if desired)

ETHNIC GROUP: Is this student Hispanic/Latino? ☐ Yes ☐ No

RACE (Choose ALL that apply): ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American  
☐ Hawaiian/Other Pacific Islander ☐ White ☐ Multi Racial (indicate which)

IF FROM ANOTHER COUNTRY: DATE ENTERED US: \_\_\_\_\_ DATE ENTERED US SCHOOL \_\_\_\_\_

LAST SCHOOL ATTENDED \_\_\_\_\_

School	City	State	Zip	Phone &/or Fax #
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Did student attend a Pre-K Program? ☐ Yes ☐ No IF YES: Public ☐ Private ☐ Head Start ☐ Special Education ☐

Date Entered 9<sup>th</sup> Grade \_\_\_\_\_ Has student ever attended Brooks County Schools: \_\_\_ Yes \_\_\_ No

Special Education \_\_\_\_ Speech \_\_\_\_ Gifted \_\_\_\_ ESOL \_\_\_\_ 504 Plan \_\_\_\_ EIP \_\_\_\_ Migrant \_\_\_\_ Remedial \_\_\_\_ Alternative\* \_\_\_\_

\*If the student was previously enrolled in an alternative school setting or subject to future disciplinary actions at their previous school, then they will be enrolled in a similar school setting or disposition in the Brooks County School System.\*

RESIDENTIAL ADDRESS: \_\_\_\_\_  
Street Address

City	County	State	Zip Code	Home Phone
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MAILING ADDRESS (if different): \_\_\_\_\_

Address City State Zip Code

Do you lack a fixed, regular, or adequate nighttime residence? \_\_\_\_ Yes \_\_\_\_ No

CHILD LIVES WITH: (Circle) Both Parents    Mother    Father    Step-Parent    Guardian    Other \_\_\_\_\_

NAME(S): \_\_\_\_\_

Who has legal custody of this child? \_\_\_\_\_ (Documentation of legal custody must be provided to the school)

STUDENT'S MEDICAL CONDITION: \_\_\_\_\_ TREATMENT \_\_\_\_\_

Other information the school needs to know about this child: \_\_\_\_\_

Permission to administer First Aid? ☐ Yes ☐ No Insurance: School ☐ Private ☐ Medicaid/Peachcare ☐ None ☐

Permission to photograph or videotape student and to publish those photos in various media? ☐ Yes ☐ No

Permission to evaluate? ☐ Yes ☐ No      Permission to transport? ☐ Yes ☐ No

Is either parent Military? ☐ Yes ☐ No Parent \_\_\_\_\_ Branch \_\_\_\_\_ Status \_\_\_\_\_

Parent #1 Name: \_\_\_\_\_ Guardian? \_\_\_\_ Yes \_\_\_\_ No  
Last First Middle Sr., Jr., II, etc.

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Parent #2 Name: \_\_\_\_\_ Guardian? \_\_\_\_ Yes \_\_\_\_ No  
Last First Middle Sr., Jr., II, etc.

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

EMERGENCY CONTACT #3 NAME: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Last First Middle Sr., Jr., II, etc.

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

EMERGENCY CONTACT #4 NAME: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Last First Middle Sr., Jr., II, etc.

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

TOTAL NUMBER LIVING IN YOUR HOUSE: \_\_\_\_\_ NUMBER OF CHILDREN IN FAMILY: \_\_\_\_\_

List ALL children living in this household (including this student)

NAME	AGE	SCHOOL	GRADE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

My child will be a: Walker \_\_\_\_ Car Rider \_\_\_\_ Bus Rider: \_\_\_\_ Morning Bus # \_\_\_\_ Afternoon Bus # \_\_\_\_

PERSON AUTHORIZED TO PICK UP STUDENT OTHER THAN THOSE LISTED ABOVE:

NAME	RELATIONSHIP	PHONE (Home and Cell, if possible)
_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONS RESTRICTED FROM PICKING UP STUDENT: (Legal documentation required if restricted person is parent)  
Name(s): \_\_\_\_\_

I affirm that the above named student (circle one) has not been / has been expelled from school attendance at any private or public school in Georgia or another state for an offense in violation of school board policies relating to weapons, alcohol, drugs, or the willful infliction of injury to another person.

*I certify that all information contained on this registration form is true and correct.  
I understand that I must report any change of residence and submit new proof of residence to this school.*

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# BROOKS COUNTY SCHOOLS

## School-Based Student Health Care

**PLEASE READ CAREFULLY AND FILL OUT THIS CONSENT FORM IN ORDER FOR YOUR CHILD TO USE THE HEALTH CLINIC. ONCE COMPLETED, RETURN THIS PAGE TO YOUR CHILD'S TEACHER.**

I give my consent for \_\_\_\_\_  
(Please print child's full legal name)  
to receive medical care at the school-based clinic. I authorize a designated health professional to provide necessary and/or advisable treatment for my child. I give my permission for necessary medical tests, procedures, and treatment in the medical evaluation and management of my child's medical care.

Birth Date \_\_\_\_\_ Homeroom Teacher \_\_\_\_\_ Grade \_\_\_\_\_

**CIRCLE YES OR NO FOR THE FOLLOWING:**

**ALLERGIES TO MEDICINE: (YES or NO)**

If YES, explain \_\_\_\_\_

**ALLERGIES TO ANYTHING OTHER THAN MEDICINE: (YES or NO)**

If YES, explain \_\_\_\_\_

**CURRENT MEDICATION: (YES or NO)**

If YES, explain \_\_\_\_\_

**CHRONIC MEDICAL ILLNESSES PAST OR PRESENT: (YES or NO)**

If YES, explain \_\_\_\_\_

All health clinic services are provided at **NO COST** to the patient. However, to help with possible outside referrals, PLEASE CHECK if either of the following applies to your child:

\_\_\_ Private medical/health insurance: If yes, with whom? \_\_\_\_\_  
\_\_\_ Peachcare of Georgia  
\_\_\_ Medicaid/AFDC. Family Case Number: \_\_\_\_\_  
\_\_\_ None

We can now provide Telehealth services for doctor's appointment at your convenience. Are you interested in this service for your child? \_\_\_ Yes \_\_\_ No

I have completely disclosed all known allergies, chronic illnesses, current medications, and prior medications or drugs that have resulted in adverse reactions with respect to my child. I have read and completed this consent form for my child. I understand that any questions I may have concerning the clinic can be answered by calling the school and asking for the school nurse.

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Date)

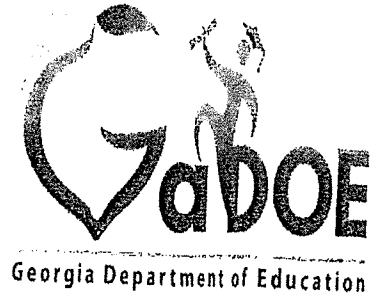
Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Alternative Contact Person: \_\_\_\_\_ Alternative Number: \_\_\_\_\_

Primary Care Physician (Doctor): \_\_\_\_\_

Georgia Department of Education  
ESOL & Title III Unit

Required Home Language Survey  
*Encuesta obligatoria en el idioma nativo*



Dear Parent or Guardian:  
*Estimado padre o tutor:*

In order to provide your child with the best possible education, we need to determine how well he or she speaks and understands English. This survey assists school personnel in deciding whether your child may be a candidate for additional English language support. Final qualification for language support is based on the results of an English language assessment.

*Para proporcionar a su hijo la mejor educación posible, debemos determinar qué tan bien habla y entiende el inglés. Esta encuesta ayuda al personal de la escuela a determinar si su hijo puede ser un candidato para recibir apoyo adicional en inglés. La calificación final para el apoyo idiomático está basada en los resultados de una prueba en inglés.*

Thank You  
*Gracias*

Student Name: \_\_\_\_\_ School \_\_\_\_\_

*Nombre del estudiante:* \_\_\_\_\_ *Escolar* \_\_\_\_\_

Language Background:  
*Antecedentes idiomáticos:*

1. Which language does your child best understand and speak?  
*¿Qué idioma su hijo entiende y habla mejor?*

\_\_\_\_\_ English \_\_\_\_\_ Spanish \_\_\_\_\_ Other: \_\_\_\_\_  
*Ingles Espanol Otro:*

2. Which language does your child most frequently speak at home?  
*¿Qué idioma su hijo habla con mayor frecuencia en el hogar?*

\_\_\_\_\_ English \_\_\_\_\_ Spanish \_\_\_\_\_ Other: \_\_\_\_\_  
*Ingles Espanol Otro:*

3. Which language do adults in your home most frequently use when speaking with your child?  
*¿Qué idioma usan con mayor frecuencia los adultos del hogar cuando hablan con el niño? .*

\_\_\_\_\_ English \_\_\_\_\_ Spanish \_\_\_\_\_ Other: \_\_\_\_\_  
*Ingles Espanol Otro:*

Language for School Communication:  
*Idioma para la comunicación con la escuela:*

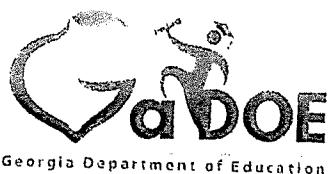
4. In which language would you prefer to receive all school information?  
*¿En qué idioma prefiere recibir toda la información escolar?*

\_\_\_\_\_ English \_\_\_\_\_ Spanish \_\_\_\_\_ Other: \_\_\_\_\_  
*Ingles Espanol Otro:*

Signature of Parent/Guardian/Other  
*Firma del padre/tutor/otro*

\_\_\_\_\_  
Date  
*Fecha*

This form is a document of the student's permanent record folder. If necessary, a copy of this form should be given to the ESOL teacher. *Este document es parte del registro permanenté de los estudiantes. Si es necesario, se prude dar una copia de esta forma a la maestro de inglés.*



Educating Georgia's Future

School District: Brooks County Schools

Date: \_\_\_\_\_

### Parent Occupational Survey

Please complete this form to determine if your child(ren) qualify to receive supplemental services under Title I, Part C

Name of Student(s)	Name of School	Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

1. Has anyone in your household moved in order to work in another city, county, or state, in the last three (3) years? ☐ Yes ☐ No
2. Has anyone in your household been involved in one of the following occupations, either full or part-time or temporarily during the last three (3) years? ☐ Yes ☐ No

If you answer "yes", check all that applies:

- ☐ 1) Planting/Picking vegetables (tomatoes, squash, onions, etc.) or fruits (grapes, strawberries, blueberries, etc.)
- ☐ 2) Planting, growing, cutting, processing trees (pulpwood), or raking pine straw
- ☐ 3) Processing/Packing agricultural products
- ☐ 4) Dairy/Poultry/Livestock
- ☐ 5) Packing/Processing meats (beef, poultry, or seafood)
- ☐ 6) Commercial fishing or fish farms
- ☐ 7) Other (Please specify occupation): \_\_\_\_\_

Names of Parent(s) or Legal Guardian(s) \_\_\_\_\_

Current Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Thank You! Please return this form to the school

Please maintain original copy in your files.

MEP funded school/district: Please give this form to the migrant liaison or migrant contact for your school/district.

Non-MEP funded (consortium) school/districts: When at least one "yes" and one or more of the boxes from 1 to 7 is/are checked, districts should fax occupational surveys to the Regional Migrant Education Program Office serving your district. For additional questions regarding this form, please call the MEP office serving your district:

GaDOE Region 1 MEP, 201 West Lee Street, Brooklet, GA 30415  
Toll Free (800) 621-5217 Fax (912) 842-5440

GaDOE Region 2 MEP, 221 N. Robinson Street, Lenox, GA 31637  
Toll Free (866) 505-3182 Fax (229) 546-3251

Family Contacted/Attempt Date: \_\_\_\_\_

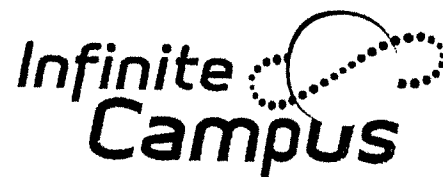
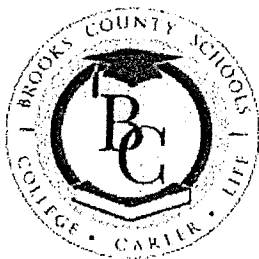
Sent to Regional Office on: \_\_\_\_\_

1854 Twin Towers East • 205 Jesse Hill Jr. Drive • Atlanta, GA 30334 • [www.gadoe.org](http://www.gadoe.org)

Richard Woods, Georgia's School Superintendent

An Equal Opportunity Employer





Dear Parents,

Brooks County School System is proud to provide access to the Infinite Campus Portal. The portal can be accessed at <https://campus.brooks.k12.ga.us/campus/portal/brooks.jsp> or via the Campus Portal App found in the app store with your smart phone. Typically, the parents and legal guardian are the only people who should be able to access the students' academic records. Please fill out and return the form below to help us correct our records and configure your account appropriately. We will e-mail your username and password to you at the e-mail you specify below.

Parent/Guardian 1

Parent/Guardian 2

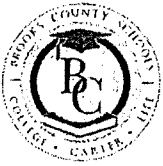
Last Name	_____	_____
First Name	_____	_____
E-mail	_____	_____
Home Phone	_____	_____
Cell Phone	_____	_____
Work Phone	_____	_____
Mailing Address	_____	_____
City/State/Zip	_____	_____
Street Address	_____	_____
City/State/Zip	_____	_____

Student Information: (You may register up to 4 students with one form.)

	Student 1	Student 2	Student 3	Student 4
School				
Grade				
Last Name				
First Name				
Birth Date				
Relation to P/G 1				
Relation to P/G 2				

For further assistance, please contact Kathy Flowers, Data Manager at [kflowers@brooks.k12.ga.us](mailto:kflowers@brooks.k12.ga.us) or 229-263-8606 ext 3030.

For Office Use Only: Rec'd. \_\_\_\_\_  
Acct. \_\_\_\_\_ E-mailed \_\_\_\_\_



**Brooks County Board of Education**  
**Transportation Department**  
1081 Barwick Road  
Quitman, Georgia 31643  
Phone: 229-588-2340  
Jim Goodson, Transportation Director

**PLEASE RETURN THIS SHEET TO THE BUS DRIVER TOMORROW**  
**THANK YOU!**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

School Attending: \_\_\_\_\_

Student's Complete 911 Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Number: \_\_\_\_\_ Parent Cell Number: \_\_\_\_\_

Morning Bus Number: \_\_\_\_\_

Afternoon Bus Number: \_\_\_\_\_

Address if riding a different bus in the afternoon: \_\_\_\_\_

City: \_\_\_\_\_

Student Lives With: Both Parents \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Guardian \_\_\_\_\_

Father's Name: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Guardian's Name: \_\_\_\_\_ Cell Number: \_\_\_\_\_

IN CASE OF EMERGENCY AND WE CAN NOT REACH THE PARENT/GUARDIAN, PLEASE LIST TO EMERGENCY CONTACTS:

Name: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Name: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Medical information driver may need to know (allergies to medication, bee stings, frequent nose bleeds, seizures, etc.)

\_\_\_\_\_  
\_\_\_\_\_